



Missouri Department of Health and Senior Services

P.O. Box 570, Jefferson City, MO 65102-0570 Phone: 573-751-6400 FAX: 573-751-6010

Richard C. Dunn
Director



Bob Holden
Governor

November 10, 2003

**PLEASE GIVE THIS LETTER AND ATTACHMENTS TO YOUR HOME HEALTH
AGENCY ADMINISTRATION**

Dear Home Health Agency Administrator,

Enclosed you will find:

The annual statistical report form for reporting **2003** information about your home health agency's activity. This information is required of all Missouri licensed home health agencies on an annual basis.

**THIS INFORMATION IS DUE IN OUR OFFICE BY JANUARY 31, 2004.
YOUR HOME HEALTH AGENCY LICENSE WILL NOT BE RENEWED IF THIS
REPORT IS NOT SUBMITTED.**

Please carefully read all instructions and definitions found in front of this form so that you have a clear understanding of what data is being collected and how to complete the form. Please cross-reference sections which are supposed to balance in order to submit correct information (i.e., if admissions are reported in more than one section, the total number of admissions should always be the same number). Check addition carefully. This is the most common error found in the form.

Although you will send these reports to our office, the Missouri Alliance for Home Care (MAHC) will again be compiling the information for publication. If you wish to be included in the annual report book and/or disks **you must also submit a copy directly to the MAHC office**. Please call our office at 573/751-6336 with any questions regarding this report or 573/634-7772 about MAHC publications. Information received in this office, not addressed in confidentiality laws, is available to the public.

Sincerely,

Linda Grotewiel, R.N., Administrator
Bureau of Home Care
and Rehabilitative Standards

www.dhss.state.mo.us

The Missouri Department of Health and Senior Services protects and promotes quality of life and health for all Missourians by developing and implementing programs and systems that provide: information and education, effective regulation and oversight, quality services, and surveillance of diseases and conditions.

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER: Services provided on a nondiscriminatory basis.

ATTENTION: New V- Codes requirements affect this report.

In section 10 (clients by primary diagnosis at time of admission) add any clients who have a primary diagnosis requiring a V Code below line r. (Unknown) on page 4. These clients should be included in your total on section 10 (line s) and on page 1, line 3 (a).

***Home Health Agency Annual Report
January 1 through December 31, 2003***

Please read all instructions before completing this report.

Responses are DUE by January 31, 2004

Return original of this form to:
Missouri Department of Health and Senior Services
Bureau of Home Care and Rehabilitative Standards
P.O. Box 570
Jefferson City, MO 65102
(573) 751-6336

AND

If your company wants to be listed in the MAHC
2003 Home Health Agency Annual Report Book and Disks,
mail a photocopy to:
Missouri Alliance for Home Care
2420 Hyde Park, Suite A
Jefferson City, MO 65109-4731

HOME HEALTH AGENCY ANNUAL REPORT DEFINITIONS AND INSTRUCTIONS

PLEASE READ THESE INSTRUCTIONS BEFORE COMPLETING THE ANNUAL REPORT. All information given in this Annual Report should be for services rendered to clients in Missouri. Please do not include data on clients residing in states other than Missouri.

GENERAL DEFINITIONS

● **Agency Name and Address** - (reported on page 1) - List only the name and location of the **licensed** agency in Missouri for which this data is reported. Do not list the home office/corporate headquarters if that is not the licensed agency submitting this data.

● **County** - (listed on page 1) - Please list the county **in Missouri** where the parent office of the agency is located. Please refer to the county codes listed on the last page of these instructions. Enter the appropriate three-digit code on page 1 of the Annual Report.

● **Number of Branch Offices** - List the total number of branch locations of the agency as of December 31 of this report year.

● **Unduplicated Intermittent Admissions** - (reported on page 1, Item 1) - The number of individuals receiving **intermittent** service from an agency during the report year counted only once, regardless of the number of services, frequency of admission, or payor source.

● **Admissions** - [reported on page 1, Item 3(a)] - The total number of admissions during the report year regardless of the number of individuals involved. For example, the same individual admitted more than once during the reporting period would be counted each time admitted.

● **Intermittent (Visits)** - Direct face-to-face contact with a client for the purpose of delivering service measured in visits regardless of length of time of the visits or payment source. Include all visits made during the report year, including visits for clients already on service at the beginning of the report year. Intermittent data is required information. Agencies must complete **all** sections of the Annual Report form.

● **Medicare Clients** - **IN ALL APPLICABLE SECTIONS OF THIS FORM**, report all Medicare clients in the Medicare column. This includes fee-for-service **and** Medicare HMO patients.

ITEM-BY-ITEM INSTRUCTIONS

ITEM 1 **UNDUPLICATED INTERMITTENT ADMISSIONS:** Enter the unduplicated intermittent admissions (the number of individuals receiving **intermittent** service from an agency during the report year counted only once, regardless of the number of services, frequency of admission, or payor source) for the agency from the period January 1 - December 31 of the report year. The total of this line **will not** correspond with any other totals reported on this Annual Report.

ITEM 2 **INTERMITTENT CENSUS ON JANUARY 1:** Enter the number of clients receiving **intermittent** services at the beginning of the business day on January 1 of the report year.

ITEM 3 **INTERMITTENT ADMISSION AND DISCHARGE SUMMARY**

(a) **Admissions:** Enter the number of **intermittent** admissions - those admitted **after** the beginning of the business day on January 1 of the report year. (See definition above for "Admissions.")

(b) **Discharges:** Enter the number of times **intermittent** services to clients were terminated in the report year.

ITEM 4 **INTERMITTENT CENSUS ON DECEMBER 31:** Enter the number of clients receiving **intermittent** services at the end of the business day on December 31 of the report year.

- ITEM 5 INITIAL CONTACT / REFERRAL SOURCE: Provides information regarding clients who are referred **and** admitted to the agency. Initial contact refers to the person or agency originating the referral. Enter the number of referrals in the appropriate spaces. The total (g) will equal the total of Item 3, line (a).
- ITEM 6 NON-ADMITTED CLIENTS: Provides information regarding the total number of client referrals during the report year for which the agency intended to provide service based on a request for service but the client was not admitted to the agency for the reasons listed on the Annual Report form. Enter in the appropriate space the number of persons with whom an initial contact was made by the agency but who were not subsequently admitted to services.
- ITEM 7 DISPOSITION UPON DISCHARGE: Refers to the level of care to which the client was discharged upon termination of services. Self/Family Care includes independent resources such as family and neighbors. Do not include clients who are discharged (or transferred) from one source of payment and immediately receive services under another payment source; only those discharged **from the agency** should be counted here. The total (k) will equal the total of Item 8, line (f). The total (k) will also equal the total of Item 3, line (b).
- ITEM 8 CONDITION UPON DISCHARGE: Refers to the condition of the client at the time services were terminated. Do not include clients who are discharged (or transferred) from one source of payment and immediately receive services under another payment source; only those discharged **from the agency** should be counted here. The total (f) will equal the total of Item 7, line (k). The total (f) will also equal the total of Item 3, line (b).
- ITEM 9 VISITS BY DISCIPLINE & PRINCIPAL PAYOR SOURCE: Include the number of visits made for each discipline and principal payor source listed. Include all visits, made during the report year, including visits for clients already on service at the beginning of the report year. The total (h) will equal the total number of visits listed on the last line of Item 12.
- ITEM 10 CLIENTS BY PRIMARY DIAGNOSIS: List the number of clients according to the primary diagnosis at the time of admission to the agency. Only include admissions made after January 1 and through December 31 for the report year. The total (s) will equal the total of Item 3, line (a).
- ITEM 11 CLIENTS BY AGE: List the number of clients according to age at the time of admission to the agency. Only include admissions made after January 1 and through December 31 of the report year. The age categories listed correspond with the age guidelines for the EPSDT program and other funding sources. The total (n) will equal the total of Item 3, line (a).
- ITEM 12 NUMBER OF ADMISSIONS, VISITS AND HOURS BY COUNTY: List the intermittent admissions and visits made within each county. In the admissions columns, only include admissions made after January 1 and through December 31 of the report year. In the visits column, include all visits during the report year, including visits for clients already on service at the beginning of the report year. The totals at the bottom of the page will correspond as follows: intermittent total number of admissions will equal the total of Item 3, line (a); and intermittent total visits will equal the total of Item 9, line (h).

COUNTY CODES - On page 1 of the Annual Report, list the county in Missouri where the parent office of the agency is located. Use the appropriate three-digit code from the list below.

001	Adair	099	Jefferson	197	Schuyler
003	Andrew	101	Johnson	199	Scotland
005	Atchison	103	Knox	201	Scott
007	Audrain	105	Laclede	203	Shannon
009	Barry	107	Lafayette	205	Shelby
011	Barton	109	Lawrence	207	Stoddard
013	Bates	111	Lewis	209	Stone
015	Benton	113	Lincoln	211	Sullivan
017	Bollinger	115	Linn	213	Taney
019	Boone	117	Livingston	215	Texas
021	Buchanan	119	McDonald	217	Vernon
023	Butler	121	Macon	219	Warren
025	Caldwell	123	Madison	221	Washington
027	Callaway	125	Maries	223	Wayne
029	Camden	127	Marion	225	Webster
031	Cape Girardeau	129	Mercer	227	Worth
033	Carroll	131	Miller	229	Wright
035	Carter	133	Mississippi	999	Unknown
037	Cass	135	Moniteau		
039	Cedar	137	Monroe		
041	Chariton	139	Montgomery		
043	Christian	141	Morgan		
045	Clark	143	New Madrid		
047	Clay	145	Newton		
049	Clinton	147	Nodaway		
051	Cole	149	Oregon		
053	Cooper	151	Osage		
055	Crawford	153	Ozark		
057	Dade	155	Pemiscot		
059	Dallas	157	Perry		
061	Daviess	159	Pettis		
063	DeKalb	161	Phelps		
065	Dent	163	Pike		
067	Douglas	165	Platte		
069	Dunklin	167	Polk		
071	Franklin	169	Pulaski		
073	Gasconade	171	Putnam		
075	Gentry	173	Ralls		
077	Greene	175	Randolph		
079	Grundy	177	Ray		
081	Harrison	179	Reynolds		
083	Henry	181	Ripley		
085	Hickory	183	St. Charles		
087	Holt	185	St. Clair		
089	Howard	187	St. Francois		
091	Howell	189	St. Louis Co.		
093	Iron	510	St. Louis City		
095	Jackson	193	Ste. Genevieve		
097	Jasper	195	Saline		

CHECK YOUR 2003 ANNUAL REPORT TOTALS!

Avoid errors in your data reporting. Use this page as a cross-reference to be sure your section totals are correct.

NOTE: Do not include data for clients residing outside of Missouri. Only report information for services rendered to clients in Missouri.

✓	<i>Total of This Item:</i>	<i>Should Equal the following Items:</i>	<i>Other Hints</i>
	1	No other sections	
	2	No other sections	Vertically: check calculations for columns. Add Item 2 plus Item 3(a) minus Item 3(b). Should equal Item 4.
	3(a)	5(g); 10(s); 11(n) & 12 total admissions	
	3(b)	7(k) and 8(f)	
	4	No other sections	
	5(g)	3(a) total; 10(s); 11(n) & 12 total admissions	
	6	No other sections	
	7(k)	3(b) total; 8(f)	
	8(f)	3(b) total; 7(k)	
	9(h)	12 total visits	Item 9 should add correctly both vertically and horizontally.
	10(s)	3(a) total; 12 total visits	
	11(n)	3(a) total; 5(g); 10(s) & 12 total admissions	
	12 admissions	3(a) total; 5(g); 10(s) & 11(n)	
	12 visits	9(h) total	

HOME HEALTH AGENCY ANNUAL REPORT

JANUARY 1 - DECEMBER 31, 2003

Please be sure to completely read all instructions accompanying this Annual Report form. This Annual Report must be submitted to the Missouri Department of Health and Senior Services, Bureau of Home Care and Rehabilitative Standards **by January 31, 2004.**

Agency Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Number of Branch Offices as of 12-31-03 (see instructions): _____

County Code (Use ONLY the three-digit County Code listed in the instructions): _____

Check Applicable Agency Type Below (Please check ALL that apply):

- | | |
|--|--|
| <input type="checkbox"/> For-profit or Proprietary | <input type="checkbox"/> Voluntary |
| <input type="checkbox"/> Not-for-profit | <input type="checkbox"/> Government Funded and Based |
| <input type="checkbox"/> Private | <input type="checkbox"/> Chain Affiliate |
| <input type="checkbox"/> Hospital-based | <input type="checkbox"/> Sole Corporation |
| <input type="checkbox"/> Nursing Facility-based | <input type="checkbox"/> Wholly Owned or Subsidiary |
| <input type="checkbox"/> Rehab-based | <input type="checkbox"/> HMO-based |

	MEDICARE	MEDICAID	OTHER 3rd PARTY	SELF-PAY	UNREIMBURSED	TOTAL
1. UNDUPLICATED INTERMITTENT ADMISSIONS (See Instructions)	_____	_____	_____	_____	_____	_____
	MEDICARE	MEDICAID	OTHER 3rd PARTY	SELF-PAY	UNREIMBURSED	TOTAL
2. INTERMITTENT CENSUS ON JANUARY 1, 2003	_____	_____	_____	_____	_____	_____
3. INTERMITTENT ADM / DISC. SUMMARY	MEDICARE	MEDICAID	OTHER 3rd PARTY	SELF-PAY	UNREIMBURSED	TOTAL
a. ADMISSIONS	_____	_____	_____	_____	_____	_____
b. DISCHARGES	_____	_____	_____	_____	_____	_____
	MEDICARE	MEDICAID	OTHER 3rd PARTY	SELF-PAY	UNREIMBURSED	TOTAL
4. INTERMITTENT CENSUS ON DECEMBER 31, 2003	_____	_____	_____	_____	_____	_____

**HOME HEALTH AGENCY ANNUAL REPORT
JANUARY 1 - DECEMBER 31, 2003**

**5. INITIAL CONTACT / REFERRAL SOURCE
(CLIENTS REFERRED AND ADMITTED TO AGENCY)**

INTERMITTENT

- a. HOSPITAL
- b. PHYSICIAN
- c. PAYOR (HMO, PPO, etc.)
- d. FAMILY / FRIEND / SELF
- e. NURSING HOME
- f. OTHER
- g. TOTAL [equals Item 3(a) total; Item 10(s); Item 11(n) & Item 12 total (admissions)]

**6. NON-ADMITTED CLIENTS & REASONS
(CLIENTS REFERRED BUT NOT ADMITTED TO AGENCY)**

INTERMITTENT

- a. SERVICES NOT AVAILABLE
- b. ADMITTED TO ACUTE OR INTERMEDIATE CARE FACILITY
- c. ADMITTED TO LONG-TERM CARE FACILITY
- d. CLIENT DOES NOT MEET AGENCY ADMISSIONS CRITERIA (physician refused certification, lack of funding, client not in agency service area, client not homebound, skilled service not needed, etc.)
- e. CLIENT REFUSED SERVICES
- f. CLIENT DECEASED
- g. CLIENT CHOSE DIFFERENT AGENCY
- h. OTHER (i.e., moved, unable to locate, etc.)
- i. TOTAL (does not equal other sections of report)

7. DISPOSITION UPON DISCHARGE

INTERMITTENT

- a. SELF
- b. FAMILY
- c. ACUTE IN-PATIENT HOSPITAL
- d. SKILLED NURSING FACILITY
- e. RESIDENCE THAT PROVIDES FORMAL SUPPORT
- f. HOSPICE
- g. OTHER HOME CARE ORGANIZATION (EXCEPT HOSPICE)
- h. DEATH
- i. OTHER
- j. UNKNOWN
- k. TOTAL [equals Item 3(b) total and Item 8(f)]

HOME HEALTH AGENCY ANNUAL REPORT

JANUARY 1 - DECEMBER 31, 2003

8. **CONDITION UPON DISCHARGE**

INTERMITTENT

- a. IMPROVED
- b. NO CHANGE
- c. REGRESSED
- d. EXPIRED
- e. UNKNOWN
- f. TOTAL [equals Item 3(b) total and Item 7(k)]

9. VISITS BY DISCIPLINE & PRINCIPAL PAYOR SOURCE

MEDICARE

MEDICAID

OTHER 3RD
PARTY

SELF- PAY

UNREIMBURSED

TOTAL

- a. SKILLED NURSING
- b. PHYSICAL THERAPY
- c. SPEECH PATHOLOGY
- d. OCCUPATIONAL THERAPY ..
- e. MEDICAL SOCIAL SERVICES
- f. HOME HEALTH AIDE
- g. OTHER
- h. TOTAL [equals total of Item 12
(visits)]

[illegible]

10. CLIENTS BY PRIMARY DIAGNOSIS (ICD-9CM) AT TIME OF ADMISSION
(DO NOT INCLUDE CENSUS ON JANUARY 1)

INTERMITTENT

- | | | |
|----|--|-----------|
| a. | INFECTIVE & PARASITIC | (000-139) |
| b. | NEOPLASMS | (140-239) |
| c. | ENDOCRINE, NUTRITIONAL & METABOLIC | (240-279) |
| d. | BLOOD & BLOOD-FORMING ORGANS | (280-289) |
| e. | MENTAL DISORDERS | (290-319) |
| f. | NERVOUS SYSTEM & SENSE ORGANS | (320-389) |
| g. | CIRCULATORY SYSTEM | (390-459) |
| h. | RESPIRATORY SYSTEM | (460-519) |
| i. | DIGESTIVE SYSTEM | (520-579) |
| j. | GENITOURINARY SYSTEM | (580-629) |
| k. | COMPLICATIONS OF PREGNANCY, CHILDBIRTH, PUERPERIUM | (630-676) |
| l. | SKIN & SUBCUTANEOUS TISSUE | (680-709) |
| m. | MUSCULO SKELETAL SYSTEM & CONNECTIVE TISSUE | (710-739) |
| n. | CONGENITAL ANOMALIES | (740-759) |

[illegible]

HOME HEALTH AGENCY ANNUAL REPORT

JANUARY 1 - DECEMBER 31, 2003

- o. CONDITIONS ORIGINATING IN PERINATAL PERIOD (760-779) _____
- p. SYMPTOMS & ILL-DEFINED CONDITIONS (780-799) _____
- q. INJURY & POISONING (800-999) _____
- r. UNKNOWN _____
- s. TOTAL [equals Item 3(a) total Item 12 total (admissions)] _____

11. CLIENTS BY AGE (AT TIME OF ADMISSION)
DO NOT INCLUDE CENSUS ON JANUARY 1

INTERMITTENT

- a. LESS THAN 1 YEAR _____
- b. 1 - 5 _____
- c. 6 - 9 _____
- d. 10 - 17 _____
- e. 18 - 20 _____
- f. 21 - 54 _____
- g. 55 - 59 _____
- h. 60 - 64 _____
- i. 65 - 69 _____
- j. 70 - 74 _____
- k. 75 - 79 _____
- l. 80 - 84 _____
- m. 85 + _____
- n. TOTAL [equals Item 3(a) total; Item 5(g); Item 10(s) & Item 12 total (admissions)] _____

12. PLEASE COMPLETE THE CHART ON THE FOLLOWING PAGES, INDICATING THE INFORMATION REQUESTED:

NUMBER OF ADMISSIONS AND TOTAL VISITS BY COUNTY: Enter the number of admissions and the number of visits made within each county in the proper columns. (See instructions)

The totals at the bottom of the page will correspond as follows: intermittent total number of admissions will equal the total of Item 3, line (a); and intermittent total visits will equal the total of Item 9, line (h).

HOME HEALTH AGENCY ANNUAL REPORT

JANUARY 1 - DECEMBER 31, 2003

12. NUMBER OF ADMISSIONS AND VISITS BY COUNTY

NO.	COUNTY	NO. OF ADMS.	NO. OF VISITS	NO.	COUNTY	NO. OF ADMS.	NO. OF VISITS	NO.	COUNTY	NO. OF ADMS.	NO. OF VISITS	NO.	COUNTY	NO. OF ADMS.	NO. OF VISITS
001	Adair			049	Clinton			097	Jasper			145	Newton		
003	Andrew			051	Cole			099	Jefferson			147	Nodaway		
005	Atchison			053	Cooper			101	Johnson			149	Oregon		
007	Audrain			055	Crawford			103	Knox			151	Osage		
009	Barry			057	Dade			105	Laclede			153	Ozark		
011	Barton			059	Dallas			107	Lafayette			155	Pemiscot		
013	Bates			061	Daviess			109	Lawrence			157	Perry		
015	Benton			063	DeKalb			111	Lewis			159	Pettis		
017	Bollinger			065	Dent			113	Lincoln			161	Phelps		
019	Boone			067	Douglas			115	Linn			163	Pike		
021	Buchanan			069	Dunklin			117	Livingston			165	Platte		
023	Butler			071	Franklin			119	McDonald			167	Polk		
025	Caldwell			073	Gasconade			121	Macon			169	Pulaski		
027	Callaway			075	Gentry			123	Madison			171	Putnam		
029	Camden			077	Greene			125	Maries			173	Ralls		
031	Cape Girardeau			079	Grundy			127	Marion			175	Randolph		
033	Carroll			081	Harrison			129	Mercer			177	Ray		
035	Carter			083	Henry			131	Miller			179	Reynolds		
037	Cass			085	Hickory			133	Mississippi			181	Ripley		
039	Cedar			087	Holt			135	Moniteau			183	St. Charles		
041	Chariton			089	Howard			137	Monroe			185	St. Clair		
043	Christian			091	Howell			139	Montgomery			187	St. Francois		
045	Clark			093	Iron			141	Morgan			189	St. Louis Co.		
047	Clay			095	Jackson			143	New Madrid			510	St. Louis City		

HOME HEALTH AGENCY ANNUAL REPORT

JANUARY 1 - DECEMBER 31, 2003

NO.	COUNTY	NO. OF ADMS.	NO. OF VISITS	NO.	COUNTY	NO. OF ADMS.	NO. OF VISITS	NO.	COUNTY	NO. OF ADMS.	NO. OF VISITS	NO.	COUNTY	NO. OF ADMS.	NO. OF VISITS
193	Ste Genevieve			203	Shannon			213	Taney			223	Wayne		
195	Saline			205	Shelby			215	Texas			225	Webster		
197	Schuyler			207	Stoddard			217	Vernon			227	Worth		
199	Scotland			209	Stone			219	Warren			229	Wright		
201	Scott			211	Sullivan			221	Washington			999	Unknown		
MISSOURI TOTALS:															

**HOME HEALTH AGENCY ANNUAL REPORT
JANUARY 1 - DECEMBER 31, 2003**

COMMENTS AND/OR EXPLANATIONS

Please comment on any responses that you left not complete or responses that require clarification.

- ☐ Yes, a complete photocopy of this signed Home Health Agency Annual Report Form has been mailed to the Missouri Alliance for Home Care to be included in statewide data comparisons and reports.

Date of Completion

____/____/____

Signature of Administrator

Thank you for your cooperation in completing this survey.

If there are any questions about your responses to this survey, who should be contacted?

Name (please print)

Area Code Telephone Number ext.

Name (please print)

Area Code Telephone Number ext.

ADA STATEMENT

If you desire a copy of this publication in alternate form because of a disability, contact the Missouri Department of Health and Senior Services, Division of Administration, P.O. Box 570 Jefferson City, MO 65102; phone (573) 751-6336.

Hearing-impaired citizens may contact the department by phone through Missouri Relay (800-735-2966)